differential diagnosis cannot always be immediately made, and the elements of time and the effects of psychotherapy and of reëducation must come into consideration. In this connection the observations of Lannois and of Chavanne are of interest, who reported, in the *Lyon Méd.* of February, 1916, the examination of 1000 soldiers, in 645 apparently total, or nearly total, deafness dated from an aerial concussion, without direct traumatism, all but 2 per cent. recovered, and these were left permanently deaf in both ears.

Method of Closing Post-aural Fistula. — As an example of his method L. J. CURTIN (*Jour. Laryngol., Rhinol., and Otol.*, February, 1917) reports the case of a boy, aged eleven years, with a persistent mastoid fistula, the sequence of a simple mastoid operation two years previously. The author did a radical operation with a resultant reopening of the fistula, the closure of which was effected by refreshment of the fistulous edges and a linear reunion of the wound, avoidance of tension upon the suture being accomplished by means of a new vertical linear incision, three-fourths of an inch behind that for the immediate closure of the radical mastoid wound, a thin elevator being used for dissection of the periosteum of the resultant flap, which it was therefore possible to slip forward and suture without strain upon the edges of the anterior incision; the further postaural gap in the skin of the scalp was then filled by a skin graft from the inner side of the arm. The result in this case was healing of the radical mastoid wound by first intention and consequent obliteration of the fistulous opening a result similar to that which would have been obtainable by a still further postaural periosteal dissection and a slipping of the scalp forward for closure of the secondary opening as a substitute for the closure by the flap operaton, as has been effected, in like cases, by other surgeons.

War Injuries, Auricle and External Meatus. — MARRIAGE and CHEATTE (*Jour. Laryngol., Rhinol. and Otol.*, June, 1917). Wounds from an individual missile or from personal contact in hand-to-hand fighting vary greatly in character and in extent, the auricle may be pierced by a bullet, shredded by small pieces of rental which have passed through or remain lodged in it or it may have been almost torn away. In dealing with these cases all that is usually required is cleansing the wound, removing imbedded metal and applying antiseptic dressing, it being often possible to save a large part of the auricle by plastic operation, the chief complication being necrosis of the cartilage. Wounds of the cartilaginous portion of the canal were usually caused by missiles entering from in front or behind with or without implication of the bony canal; in one instance a bullet entered in front of the tragus; passed through the cartilaginous canal, striking the tip of the mastoid causing a slight fracture, as shown by the x-ray examination and emerging below; the wound of exit was about the size of a hazelnut and fitted in without involvement of the mastoid. The drum-head was not injured, but there was some impairment of hearing referable to the labyrinth as a result of the concussion. Mr. Arthur Cheatte reports 2 cases, 1 in which a nearly spent machine-gun bullet entered the right meatus, passing through the cartilaginous canal without injury, striking and penetrating the anterior bony wall being then deflected downward and backward and emerging behind the upper third of the sternomastoid, lodged in the collar badge, the soldier was knocked down without losing consciousness and was dazed, giddy, and sick. When seen, a few days later, there was a slight thin discharge from the ear, the cartilaginous canal was normal, but the anterior and inferior walls of the bony canal were swollen and there was a granulation obscuring the anterior half of the drum-head, there was also a healing wound one and a half inches in length behind the sternomastoid in its upper third. The patient complained of deafness and subjective noises, difficulty and pain on moving the jaw; there was no bony crepitus, but distinct synovial creaking. The voice in conversation tone was heard at a distance of six feet and the tuning-fork by bone conduction was heard in the affected ear. There was neither pain, dizziness, nystagmus nor facial paralysis. A few days later the slight discharge became offensive and facial paralysis gradually developed, but after saline syringing for a few weeks the discharge ceased and the paralysis disappeared. Examination of the drum-head which was then possible showed that it has been ruptured in the anterior inferior segment, the hearing subsequently became nearly normal. The second case was that of a lieutenant who, while looking through field glasses, was struck by a rifle bullet fired from a range of less than three hundred yards, which passed through the palm of the left hand. glanced off the malar bone and passed through the meatus cutting the auricle in half, he was unconscious for a few minutes and, on recovery, dizzy and nauseated, and had a facial paralysis which persisted for about two months. Six weeks after the injury the wounds were healed but there was complete cicatricial closure of the meatus. For five weeks after the injury he had disturbance of equilibrium and much unsteadiness in walking and had not been able to hear in the affected ear. The examination made two months after the injury showed the hearing to be absolutely wanting in the left ear either aerially or by bone conduction and there was no nystagmus on rotation.

Contribution to the Etiology and Pathogenesis of Otogenic Sinus Phlebitis.—(*Journal of Laryngol., Rhinol., and Otol.*, vol. xxxi, No. 12). —In this paper, based upon the observation of 20 cases of otogenic sinus phlebitis operated upon by the author and statistically reported, it is concluded that the jugular bulb is the most frequent place for the inception of otogenic thrombophlebitis, the fact being that in 16 out of 53 cases in which a clot was found in the sigmoid sinus, no bleeding could be produced by applying the sharp spoon in the direction of the bulb because there was a clot there, while profuse bleeding resulted from the application of the sharp spoon in the opposite direction. In this respect the author supports Jansen in his opinion that the jugular bulb plays an important part as the place of origin of thrombophlebitis, but disagrees with the latter writer in the opinion that this applies only to thrombophlebitis caused by acute middle ear inflammation. The majority of the author's cases, where the jugular bulb probably or certainly was the primary place of origin, were cases of chronic middle ear suppuration frequently accompanied by cholesteatomatous accumulation. In the author's opinion the otogenic sepsis is a pathogenic unity which, perhaps with a few exceptions, is caused by a thrombophlebitis of the sigmoid sinus or of the bulb or of both united.